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Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS) I am pleased to submit comments on the proposed regulations regarding Medicaid Coverage for Rehabilitative Services, published at 72 Fed. Reg. 45201 (August 13, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

The rehabilitative services option is the primary basis of Arizona's outpatient behavioral health services program. Some of the behavioral health services AHCCCS provides under the rehabilitation services option include screening, assessment, and evaluation; counseling, including individual, group, and family therapy; behavior management services, including peer support; psychosocial rehabilitation, including living skills training; and medication management. AHCCCS has elected to provide most physical, occupational, and speech and hearing services under the separate state plan option related to those services; therefore, these comments relate specifically to the coverage of behavioral health services.

Rehabilitative services are essential to help people with mental illness improve or maintain their functioning, allowing people with mental illness to reduce their dependence on inpatient services.

42 C.F.R. § 440.130(d)(1)(iii)
The proposed rule defines the term "qualified providers of rehabilitative services." It is unclear if this definition includes peer support services, which, as provided in State Medicaid Director Letter #07-011 "are an evidence-based mental health model of care" that "can be an important component in a State's delivery of effective treatment." AHCCCS recommends clarifying in the preamble to the final rule that peer support specialists can be qualified providers of behavioral health rehabilitative services.

42 C.F.R. § 440.130(d)(1)(iv)
The definition of "under the direction of" in the proposed rule requires that a licensed practitioner supervise the provision of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. While the proposed rule states that this definition applies specifically to providers of those services, the last sentence of the definition states that the "language is not meant to exclude appropriate supervision arrangements for other rehabilitative services." AHCCCS is concerned that this language will be construed as requiring comparable levels of supervision for behavioral health services. Arizona is experiencing a shortage of licensed behavioral health providers, and requiring a comparable level of supervision for behavioral health services would severely jeopardize the availability of behavioral health services; therefore, AHCCCS recommends that the last sentence of the definition be removed.

42 C.F.R. § 440.130(d)(1)(v)
The proposed rules define "rehabilitation plan" and introduce requirements for the written rehabilitation plan. The regulation is silent on the relationship between the rehabilitation plan and the treatment plan, and AHCCCS is

concerned that the proposed rules will require two plans and two planning processes for the written rehabilitation plan and a separate treatment plan. AHCCCS recommends that the rules clarify that the treatment plan can be the written rehabilitation plan (as long as the treatment plan includes all requirements for the rehabilitation plan) rather than require two separate planning processes and plans.

42 C.F.R. § 440.130(d)(1)(vi)
The proposed regulation defines "restorative services"; however, it is unclear how the term will be used in the final rule because the term is not used in the proposed rule or the statute. The definition states that the "emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past." AHCCCS is concerned that this definition may be used to exclude services for young children because the child's capacity to perform the function may not be known. AHCCCS is recommending that the proposed rules or the preamble clarify the application of this rule to young children who had not yet reached developmental milestones.

The proposed definition also states that "services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services." It is unclear if this sentence allows the rehabilitation goal to be maintenance of function; however, maintenance of function is often an appropriate goal for individuals with behavioral health conditions. AHCCCS recommends that the regulations are written or applied in a manner consistent with the Medicare Hospital Manual § 230.5(B)(3) which provides: "For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement."

42 C.F.R. § 440.130(d)(3)(xi)
The proposed rule requires that the written rehabilitation plan "indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." This is apparently included to ensure patients have a choice of providers; yet there are already several processes in place to ensure patient choice, including informed consent and the grievance and appeal process. Further, in the managed care setting, individuals are provided a comprehensive directory of network providers. Listing all providers in the rehabilitation plan is onerous and makes the rehabilitation plan unwieldy and can lead to a delay in accessing services.

42 C.F.R. § 440.130(d)(3)(xiv)
The proposed rule provides, "If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods." Consistent with the above comment regarding the definition of "restorative services," AHCCCS recommends that the regulation be written or applied in a manner consistent with Medicare.
The Medicare Hospital Manual § 230.5(B)(3) provides:

> "The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.
>
> "It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."
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> "Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the

> evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

42 C.F.R. § 440.130(d)(3)(xv)
The proposed rules require the rehabilitation plan to "document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan." This requirement can become a barrier to services for individuals who refuse to sign the form for reasons related to their disease or disability. For example, individuals who have been court-ordered to receive treatment may refuse to sign the form. Individuals with paranoid disorders or cognitive disabilities such as dementia, may refuse to sign because they do not understand. AHCCCS recommends that there be a means of opting out, if the reason for failing to obtain the individual's signature is included in the rehabilitation plan.

42 C.F.R. § 440.130(d)(3)(xvi)
The proposed regulation requires that the rehabilitation plan "document that the services have been determined to be rehabilitative services consistent with the regulatory definition." It seems unreasonable to require a clinician to document compliance with the proposed regulation, and including this makes the document more complex for both clinicians and individuals and their families. As required by 42 C.F.R. § 440.130(d)(3)(x), the document has already been signed by the individual responsible for developing the plan. Individuals may be even more uncomfortable signing the document. AHCCCS recommends deleting this provision.

42 C.F.R. § 440.130(d)(3)(xvii)
Under 42 C.F.R. § 440.130(d)(3)(i), the rehabilitation plan must "be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living." The requirement that the rehabilitation plan must "include the individual's relevant history, current medical findings, contraindications" essentially forces the rehabilitation plan to rewrite or duplicate the comprehensive assessment required by 42 C.F.R. § 440.130(d)(3)(i). This requirement contains unnecessary work and makes the document even larger and more confusing for the individual or their family. AHCCCS recommends deleting this provision.

42 C.F.R. § 441.45(a)(5)
The proposed rule requires the state to "ensure the State plan rehabilitative services . . . specifies the methodology under which rehabilitation providers are paid." In the past year, several states have been forced by CMS to abandon case rate or the bundled approach which is paying for services and pay for billing of services in 15 minute increments. This approach significantly increases the amount of time that clinicians must spend completing paperwork and thus reduces the amount of time available to spend with clients. AHCCCS recommends that CMS provide states with necessary flexibility in reimbursement.

42 C.F.R. § 441.45(b)(1)
This section prohibits federal financial participation (FFP) for services that are "intrinsic elements of programs other than Medicaid." While the rule provides a few examples of services that are believed to be intrinsic elements of other non-Medicaid programs, it fails to identify the criteria used to determine whether a service is an intrinsic element of another program. This vague standard provides no guidance to states trying to implement the proposed regulations. At the same time, it appears to provide great latitude to CMS and the Office of Inspector General in interpreting this standard. Further, this appears to run counter to the goals developed by the President's New Freedom Commission on Mental Health. The report establishes goal 2.3, "align relevant Federal programs to improve access and accountability for mental health services" and states that "States will have the flexibility to combine Federal, State, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice systems." The "intrinsic element" standard establishes a new bureaucratic boundary that will have a chilling effect on state's efforts. AHCCCS recommends deleting this entire portion of the proposed rule.

Thank you for this opportunity to comment on the proposed regulation.

Sincerely,

Anthony D. Rodgers,
Director